



Union Athletic Training Center
2025-2026 Preparticipation
Physical Examination

PARENTS: keep the original for your records,
provide a COPY to your coach or email to
newman.dan@unionnps.org

Date of exam: _____

Last Name _____ First Name _____ Age _____ Date of Birth _____
Grade (2025-2026) _____ Union Student ID# _____ Sex _____ Sport/Activity _____
Personal Physician _____ Phone _____

List any past and current medical conditions (asthma, diabetes, anemia, etc.): _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all (pollens, food, medicines, stinging insects): _____

Patient Health Questionnaire Version 4 (PHQ-4) Over the last two weeks, how often have you been bothered by any of the following (circle response):

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 & 2, or questions 3 & 4] for screening purposes)

GENERAL QUESTIONS Explain "Yes" answers at the end of this form.

Circle questions if you do not know the answer.

	YES	NO
1 Do you have concerns that you would like to discuss with your provider?		
2 Has a provider ever denied or restricted your participation in sports for any reason?		
3 Do you have any ongoing medical issues or recent illness?		

HEART HEALTH QUESTIONS ABOUT YOU

	YES	NO
4 Have you ever passed out or nearly passed out during or after exercise?		
5 Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6 Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?		
7 Has a doctor ever told you that you have any heart problems?		
8 Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?		
9 Do you get light-headed or feel more short of breath than your friends during exercise?		
10 Have you ever had a seizure?		

HEART QUESTIONS ABOUT YOUR FAMILY

	UNSURE	YES	NO
11 Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning, unexplained car accident, or sudden infant death syndrome)?			
12 Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT Syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			
13 Has anyone in your family had a pacemaker or an implanted device before age 35?			

BONE AND JOINT QUESTIONS

	YES	NO
14 Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?		
15 Do you have a bone, muscle, ligament or joint injury that bothers you?		

MEDICAL QUESTIONS

	YES	NO
16 Do you cough, wheeze or have difficulty breathing during or after exercise?		
17 Are you missing a kidney, eye, a testicle, your spleen or any other organ?		
18 Do you have groin, testicle pain or a painful bulge or hernia in the groin area?		
19 Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20 Have you had a concussion or a head injury that caused confusion, a prolonged headache or memory problems?		
21 Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22 Have you ever become ill while exercising in the heat?		
23 Do you or someone in your family have sickle cell trait or disease?	UNSURE	
24 Have you ever had or do you have any problems with your eyes or vision?		
25 Do you worry about your weight?		
26 Are you trying to or has someone recommended that you gain or lose weight?		
27 Are you on a special diet or do you avoid certain types of foods or food groups?		
28 Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS

	N/A	YES	NO
29 Have you ever had a menstrual period?			
30 How old were you when you had your first menstrual period?			
31 When was your most recent menstrual period?			
32 How many periods have you had in the past 12 months?			

Please explain "YES" answers here: _____

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. □

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to above questions are complete and correct. □

Parent/Guardian Signature _____

Date _____



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Physical Examination Page 2

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Last Name _____ First Name _____
Age _____ Date of Birth _____ Grade (2025-2026) _____ Union Student ID# _____ Sex _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ BP: _____ / _____ Pulse: _____ Vision: R 20/ _____ L20/ _____ Corrected: Y N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance ⊗ Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, ears nose and throat ⊗ Pupils equal ⊗ Hearing		
Lymph nodes		
Heart ⊗ Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin ⊗ Herpes simplex virus (HSV), lesions of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional ⊗ Double-leg squat test, single leg squat test and box drop or step drop test		

_____ Medically eligible for all sports without restriction
_____ Medically eligible for all sports with recommendations for further evaluation or treatment of: _____
_____ Medically eligible for certain sports: _____
_____ Not medically eligible pending further evaluation for: _____
_____ Not medically eligible for any sports

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participation the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of health care provider (print or type): _____ Date: _____
Address: _____ Phone: _____
Signature of health care provider: _____